

# Exhibit 3

**DECLARATION OF MAJOR SCOTT STANLEY**

I, Major Scott Stanley, hereby state and declare as follows:

1. I am an Army Preventive Medicine Officer. I hold a PhD in genetics and have over 10 years of experience working in novel drug and vaccine development prior to joining the Army. I am currently employed by the U.S. Army as the Joint Force Health Protection Officer. I have held this position since June of 2021. I previously served as the Medical Advisor to the Assistant Secretary of State for the Bureau of Population, Refugees, and Migration, Department of State. My responsibilities as the Joint Force Health Protection Officer include: coordinating with the Office of the Secretary of Defense, the Combatant Commands, and the Services on health service support and preventive medicine; providing expert analyses and medical recommendations impacting the Joint Force; providing Military medical advice to the Chairman of the Joint Chiefs of Staff through the Joint Staff Surgeon on all matters related to force health protection, including: Public Health, comprehensive health surveillance and risk management, laboratory services, and veterinary services; and providing expertise across the continuum of force health protection activities including medical intelligence, health threat analysis, infectious disease prevention, industrial hygiene, chemical, biological and toxic materials and medical countermeasures.

2. I am generally aware of the allegations set forth in the pleadings filed in this matter. This declaration is based on my personal knowledge, as well as information made available to me during the routine execution of my official duties.

**COVID-19 IMPACTS ON THE FORCE**

3. As of 5 August 2022, there have been 697,522 cases of Coronavirus Disease 2019 (COVID-19) in service members, civilian, contractors, and dependents across the Department of Defense (DoD). There have been 435,744 cases in service members alone, which have led to 96

service member deaths (89 were unvaccinated, 3 partially vaccinated, and 2 fully vaccinated but not boosted, and 2 with an unknown vaccination status (NGB)). There have been no deaths among active duty personnel since the vaccination deadlines, with over 98.9% of active duty personnel at least partially vaccinated (current as of 5 August 2022).

4. COVID-19 impacted all elements of DoD simultaneously, and required significant operational oversight by the Secretary of Defense, the Chairman of the Joint Chiefs of Staff, Secretaries of the Military Departments, the Under Secretaries of Defense, and all geographic and functional combatant commands (CCMD) (i.e., military commands that carry out broad missions and are composed of forces from the military departments) to execute their statutory responsibilities.

5. On March 25, 2020, then-Secretary of Defense Mark Esper enacted a 60-day stop movement order for all DoD uniformed and civilian personnel and their sponsored family members overseas. This measure was taken to aid in further prevention of the spread of COVID-19, to protect U.S. personnel and preserve the operational readiness of our global force.

6. Building upon previously enacted movement restrictions governing foreign travel, permanent change of station moves, temporary duty and personal leave, this stop movement order also impacted exercises, deployments, redeployments, and other global force management activities. Approximately 90,000 service members slated to deploy or redeploy within 60 days of its issuance were impacted by this stop movement order.

7. Specific examples of cancelled or curtailed training resulting from the dangers posed by the SARS-CoV-2 virus, which causes COVID-19, include the following. In March of 2020, 63 Fort Jackson recruits in a class of 940 had tested positive for the virus and caused a rescheduling of basic training activities. Also in March 2020, the United States Military Academy at West Point was on spring break when the seriousness of the pandemic came to light, forcing a

pause in the academic year until a plan could be developed to bring the cadets back to campus safely. In early April 2020, Secretary Esper authorized the Secretaries of the Military Departments to pause accessions training (i.e., training for new recruits) for two weeks. In May 2020, the Defender Europe 2020 exercise was originally supposed to deploy the largest force (20,000 service members) from the United States to Europe in over 20 years, but the event was modified to about 6,000 service members to limit troop movement. Reserve and National Guard units suspended monthly battle assemblies and drill as early as March and April 2020, and moved to virtual training. For instance, the Army Reserve announced on March 18, 2020, that it was suspending monthly battle assemblies. The Navy Reserve announced about the same time the suspension of drill weekends, and then on April 16 it announced that suspension would be extended. In Korea, United States Forces Korea (the command responsible for military operations in the country) was forced to limit travel outside of the country, and travel to and from Daegu was limited to mission-essential personnel only. In addition, the spread of the virus caused the DoD Education Activity (DoDEA) to cancel school for children in all of the schools in Daegu, and military commanders were forced to cancel all meetings, formations, and training events greater than 20 people, which severely impacted unit training which routinely requires service members to practice maneuvers and operations in large group settings.

8. Perhaps one of the more well-known examples of how the spread of COVID-19 could impact military operations, particularly among unvaccinated service members, is that of the U.S.S. Theodore Roosevelt, a nuclear-powered aircraft carrier with 4,779 personnel onboard. While conducting operations in the Pacific Ocean, the U.S.S. Theodore Roosevelt had to be diverted to the U.S. Naval Base Guam after an outbreak of SARS-CoV-2 occurred in an estimated

1,331 crew members, killing one, and resulting in the ship becoming non-operational.<sup>1</sup> Since the U.S. Navy only has 11 aircraft carriers in the total inventory, this event represented a significant reduction in the Navy's operational capacity. This example highlights not only the operational impact unmitigated spread of SARS-CoV-2 could have on the military's ability to carry out operations, but also the increased risk of transmission to those who must carry out their duties in close-quarters environments, such as service members who must work in close contact with others, sleep in open bays with tightly packed bunks, or must work in the confined areas of a ship where it is believed that such close, confined working environments contributed to higher exposure to the virus and a higher risk of infection.

9. Over the first twenty months of the pandemic, approximately 19 major training events, many of which involved preparedness and readiness training with our foreign partners, had to be canceled as a result of COVID-19. These included major training events involving tens of thousands of personnel that focus on readiness and response to events spanning a wide range of national security and international objectives, including: responses to catastrophic natural disasters, multi-national exercises with international partners to defend against military aggression, training symposiums and exercises to enhance defenses to information infrastructures, and partner capacity training for security and stability operations. While travel restrictions have generally lessened in the U.S. and globally, they continue to impact DoD operations in U.S. counties with medium to high community levels for COVID-19 and abroad where some Host Nation restrictions remain as the state of the pandemic continues to evolve with the emergency of newer, more infectious variants.

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<sup>1</sup> The New England Journal of Medicine, An Outbreak of Covid-19 on an Aircraft Carrier, <https://www.nejm.org/doi/full/10.1056/NEJMoa2019375>.

10. Further, unvaccinated individuals were unable to participate in some international training events because some partner nations had COVID-19 vaccination requirements or additional testing and quarantine requirements for country entry that degraded training value and involvement for unvaccinated individuals. There are still countries with vaccine requirements or quarantine requirements for unvaccinated individuals which would preclude an unvaccinated individual from participating in a military-to-military engagement with partner nations.

11. The loss of these training opportunities not only inhibited the development and sustainment of intra- and international relationship development that would otherwise allow for increased cooperation and understanding, but it prevented invaluable training opportunities that allow our forces, and our foreign partners, to practice interoperability and to strengthen their abilities to plan and execute combat, humanitarian, and security operations that are vital to the preservation of national security and the protection of our foreign interests.

12. As in the civilian health care system, in the early weeks and months of the pandemic, the DoD cancelled all non-essential medical procedures and surgeries and was further limited in its ability to provide medical appointments due to access restrictions to military treatment facilities (MTFs), the lack of available beds in the MTFs, and the burden on the military health system associated with caring for COVID-19 patients. This had the effect of reducing readiness as service members were, in some cases, unable to receive the care they needed to address non-emergency conditions and undergo routine medical and health assessments that are required under military directives to maintain medical readiness.

13. The military health system was also called on to support the COVID-19 response in the United States. In April of 2020, the Department of Defense converted the Jacob K. Javits Center in New York into an alternative care facility for more than 2,000 COVID-19 patients. The

United States Naval Ship (USNS) Comfort arrived in New York Harbor on March 30, 2020, while the USNS Mercy arrived in Los Angeles on March 27, 2020, to relieve pressure on local hospital systems so they could focus on life-saving COVID-19 related care. In December of 2021, the President announced plans to send an additional 1,000 military medical personnel to U.S. hospitals to join the roughly 240 personnel already deployed to seven states. These and other examples of DoD support to civil authorities served as a resource drain on the military health system and obviously directly exposed DoD personnel to the SARS-CoV-2virus.

14. Vaccinations for COVID-19 enabled the return to higher levels of occupancy in DoD facilities, and enabled DoD to hold in-person training, meetings, conferences, and other events. Vaccinations also permit service members to engage in joint training exercises with other countries that have vaccine requirements. It also reduced the testing burden on the DoD since in many instances individuals who are fully vaccinated were not required to submit to COVID-19 testing.

15. On May 26, 2020, the Secretary of Defense issued conditions-based guidance that enabled the resumption of some unrestricted official DoD travel based on the White House's Opening Up America Guidelines. On April 12, 2021, the Under Secretary of Defense for Personnel and Readiness published guidance removing some travel restrictions for fully vaccinated individuals and on September 24, 2021, the Deputy Secretary of Defense lifted travel restrictions for fully vaccinated DoD personnel.

16. According to the Director of the National Institute of Allergy and Infectious Diseases (NIAID), Dr. Anthony Fauci, as of January 2022, statistics for the U.S. population showed that an unvaccinated person has a 10-times greater chance of getting infected, a 17-times greater chance of getting hospitalized, and a 20-times chance of dying compared to a vaccinated

person.<sup>2</sup> Rates of COVID-19 cases between October and November of 2021 were lowest among fully vaccinated persons with a booster dose compared to those with just the primary series, and much lower than rates among unvaccinated persons (25.0, 87.7, and 347.8 per 100,000 population, respectively). In December of 2021, when Omicron was circulating widely, the same pattern holds (148.6, 254.8, and 725.6 per 100,000 population, for boosted, primary series only, and unvaccinated, respectively).

17. In November of 2021, the CDC found that unvaccinated individuals were 4-times more likely to test positive and 15-times more likely to die than a fully vaccinated individual. In December of 2021, unvaccinated individuals were 16 times more likely to be hospitalized with COVID-19. For hospitalized adults, the CDC found that unvaccinated people with a previous COVID-19 diagnosis were more than 5 times more likely to get re-infected than fully vaccinated people with no prior history of SARS-CoV-2 infection. This demonstrates that through the end of 2021, COVID-19 vaccines were effective at reducing the risk of becoming infected, more importantly, were highly effective at preventing hospitalizations and deaths. Although COVID-19 vaccine effectiveness (VE) has since decreased in terms of preventing infections with the emergence of the new variants and with the waning of vaccine-induced immunity, protection against hospitalization and death has remained high. The CDC published a study on January 19, 2022 that showed VE in terms of preventing hospitalization during the period when Omicron has been the dominant variant was 81% following the initial 2-shot series and 90% in those who were up to date with the recommended booster dose.

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<sup>2</sup> 20 January 2022 Blue Star Families forum. Panel Speakers: Dr. Anthony Fauci, NIAID; LTG Ronald Place, Defense Health Agency; and Maj Gen Paul Friedrichs, Joint Staff Surgeon.



18. DoD specific data has been equally compelling in terms of demonstrating the value of vaccinations. Between July and November of 2021, non-fully-vaccinated active-duty service members had a 14.6-fold increased risk of being hospitalized when compared to fully vaccinated active-duty service members. In December 2021, unvaccinated adults were 16-times more likely to be hospitalized than vaccinated adults. Furthermore, unvaccinated adults over 50 years of age were 44 times more likely to be hospitalized than individuals who were vaccinated and received a booster dose. And as mentioned previously, of the 96 deaths among uniformed service members, 92 were not fully vaccinated (another two were of unknown vaccination status, and the remaining two had not received a booster dose). Perhaps most importantly, there have been no COVID-19 related deaths among active duty personnel since the vaccination deadlines have passed.

19. While some have pointed to the increase in the number of breakthrough cases in general, and with the Delta and Omicron variants in particular, as a reason to question the effectiveness of the vaccines, it is important to keep in mind that as vaccination rates increase among service members, vaccinated service members will make up a larger percentage of the population available to become infected. In other words, vaccinated personnel are disproportionately represented in the pool of individuals exposed to the virus that causes COVID-19. Taken to the extreme, if *every* service member were vaccinated, only vaccinated service members *could* have infections. It is important to view the number of breakthrough infections in proportion to the size of the population in question, not necessarily as a reflection of vaccine effectiveness. The same holds true for vaccine effectiveness against hospitalizations. An analysis of the number of active duty Service members hospitalized due to COVID-19 between 21 July 2020 and 21 July 2022 shows an incremental increase in protection against hospitalization going from the unvaccinated, to the partially vaccinated, to the fully vaccinated, to those who received a booster. Specifically, for Active Duty Service members hospitalized (direct care in the Military

Health System only) during this two-year window, 70% were not fully vaccinated (38% were unvaccinated, 32% were partially vaccinated). As above, it is important to keep in mind that the size of the unvaccinated population during this window was decidedly smaller than the fully vaccinated population, obscuring the tangible benefit against hospitalization for the fully vaccinated.

20. Other recent media reports have cited faster waning immunity from the primary series of COVID-19 vaccines than for natural infections as evidence that the vaccines are not necessary, and may even be harmful. In one specific example, a New England Journal of Medicine article<sup>3</sup> reported effectiveness against symptomatic infections was highest in people who had received three doses of the Pfizer vaccine *and* been infected with COVID-19 (74%), previous infection alone was 50% effective, and receipt of initial two vaccine doses last year offered little, if any, protection against infection with the Omicron BA.2 sub-variant. While it is true that protection from infection wanes over time following either a COVID-19 infection or COVID-19 vaccination, protection resulting from vaccination occurs without the risks of a COVID-19 infection - a much safer way to acquire immunity. It is also important to note that the highest levels of protection reported in this study were in those cohorts that were up-to-date on their vaccines (meaning had received the recommended boosters), regardless of prior infection status. In terms of safety, 11 billion doses of COVID-19 vaccines have been administered globally, providing immense amounts of data validating the safety and efficacy of these vaccines; reputable analyses have consistently shown that the benefit-risk ratio remains overwhelmingly favorable for vaccinations to prevent significant illness or death.

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<sup>3</sup> Heba N. Altarawneh, et. al., 2022. Effects of Previous Infection and Vaccination on Symptomatic Omicron Infections. New England Journal of Medicine. Published on 15 June 2022 at NEJM.org.

21. The most recent CDC data shows that COVID-19 vaccines continue to be highly protective against severe illness and death, although they provide a lesser degree of protection against asymptomatic and mild infection in light of the latest variants<sup>4</sup>. The rates of COVID-19–associated hospitalization and death are substantially higher among unvaccinated adults than among those who are up to date with recommended COVID-19 vaccination, and emerging evidence suggests that vaccination before infection also provides some protection against post–COVID-19 conditions. *Id.*

22. Given the tangible protection the vaccines afford service members against serious illness, hospitalization, and death, it is clear that COVID-19 vaccines improve readiness and preserve the DoD’s ability to accomplish its mission. If an individual tests positive for COVID-19, they are required to isolate and are unavailable to perform their duties, even if they are asymptomatic or have mild symptoms. They also put their fellow service members at risk of infection and hospitalization and further degrade the readiness of their units, their service, and the DoD. Additionally, the vaccines have provided huge benefits to preventing infections and transmission in the past, and going forward, the vaccines will continue to provide some protection against infection, and more significantly, reduce the incidence of serious illness, long-term complications, or death. Moreover, if an unvaccinated service member in a hostile area becomes seriously ill and requires a medical evaluation, it may risk the lives of other service members or may ultimately not be possible, thus endangering the member’s life and affecting the unit’s mission.

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<sup>4</sup> Massetti GM, Jackson BR, Brooks JT, et al. Summary of Guidance for Minimizing the Impact of COVID-19 on Individual Persons, Communities, and Health Care Systems — United States, August 2022. *MMWR Morb Mortal Wkly Rep.* ePub: 11 August 2022. DOI: <http://dx.doi.org/10.15585/mmwr.mm7133e1>

23. I am aware that this declaration may be filed in multiple cases for the purpose of defending the Secretary of Defense's directive to vaccinate Service members against the COVID-19.

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Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Executed on August 15, 2022 in Washington, DC.

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